

Date: _____

CONFIRMATION OF REMOVAL FOR: _____

This is to confirm that the Department of Social Services, Caregiver Background Check Bureau, informed you that the person identified above must be removed from your facility/home. The individual must be removed because he/she has been convicted of a crime for which an exemption cannot be granted.

To confirm that the individual has been removed from your facility/home, you must sign below and return the entire notice, **within five (5) days** of the date of this notice to the address below. Retain a copy of the signed notice for your records.

Regional Office _____

Address _____

City/State/Zip Code _____

Failure to immediately remove the individual may result in an assessment of civil penalties and/or a disciplinary action including suspension of your license. If you have any questions regarding this letter, you may contact your local regional office or the Caregiver Background Check Bureau, Customer Services Section at (916) 274-6200.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses are true and correct. I confirm that the individual named above has been removed from the facility/home.

DATE INDIVIDUAL WAS REMOVED: _____

NAME OF PERSON COMPLETING THIS FORM: _____

TITLE: _____

SIGNATURE: _____

C: _____